		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028605

Facility Name: Rest Haven West Christian Nursing Center

Address: 3450 Saratoga Avenue (Number) Downers Grove (City) 60515 (Zip Code)

County: DuPage

Telephone Number: (630) 969-2000 **Fax #** (630) 969-2148

IDPA ID Number: 362382853003

Date of Initial License for Current Owners: 05/01/84

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael G. Kaplan **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,040	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	87,965	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,032	669	4,515	6,216	8
9	SNF/PED					9
10	ICF	10,032	15,231	10	25,273	10
11	ICF/DD					11
12	SC		33,521		33,521	12
13	DD 16 OR LESS					13
14	TOTALS	11,064	49,421	4,525	65,010	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.90%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 05/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 26 and days of care provided 3,840

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7**	8	9	10	
1	Dietary	641,844	79,386		721,230		721,230		721,230			1
2	Food Purchase		487,823		487,823		487,823	(13,571)	474,252			2
3	Housekeeping	200,987	31,395		232,382		232,382		232,382			3
4	Laundry	81,558	22,306		103,864		103,864		103,864			4
5	Heat and Other Utilities			200,751	200,751		200,751	2,358	203,109			5
6	Maintenance	139,594		218,806	358,400		358,400	1,768	360,168			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,063,983	620,910	419,557	2,104,450		2,104,450	(9,445)	2,095,005			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	3,031,058	254,681	13,909	3,299,648		3,299,648		3,299,648			10
10a	Therapy			803,306	803,306		803,306	(325,605)	477,701			10a
11	Activities	167,201	22,207	2,352	191,760		191,760		191,760			11
12	Social Services	115,046	7,370	3,160	125,576		125,576		125,576			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,313,305	284,258	837,127	4,434,690		4,434,690	(325,605)	4,109,085			16
	C. General Administration											
17	Administrative	73,794		351,014	424,808		424,808	(351,014)	73,794			17
18	Directors Fees											18
19	Professional Services			39,863	39,863		39,863	4,763	44,626			19
20	Dues, Fees, Subscriptions & Promotions			39,099	39,099		39,099	2,383	41,482			20
21	Clerical & General Office Expenses	593,649	11,631	54,989	660,269		660,269	45,798	706,067			21
22	Employee Benefits & Payroll Taxes			718,945	718,945		718,945	62,966	781,911			22
23	Inservice Training & Education			1,240	1,240		1,240	(1,240)				23
24	Travel and Seminar			11,306	11,306		11,306	5,669	16,975			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			79,796	79,796		79,796	10,230	90,026			26
27	Other (specify):*											27
28	**TOTAL General Administration**	667,443	11,631	1,296,252	1,975,326		1,975,326	(220,445)	1,754,881			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,044,731	916,799	2,552,936	8,514,466		8,514,466	(555,495)	7,958,971			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rest Haven West Christian Nursing Center #0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
30	Depreciation			533,360	533,360		533,360	68,278	601,638			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			312,619	312,619		312,619		312,619			32
33	Real Estate Taxes			14,311	14,311		14,311	(14,311)				33
34	Rent-Facility & Grounds							7,812	7,812			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			860,290	860,290		860,290	61,779	922,069			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		481,641		481,641		481,641		481,641			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,693	81,693		81,693		81,693			42
43	Other (specify):* Nonallowable costs			271,419	271,419		271,419	(271,419)				43
44	TOTAL Special Cost Centers		481,641	353,112	834,753		834,753	(271,419)	563,334			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,044,731	1,398,440	3,766,338	10,209,509		10,209,509	(765,135)	9,444,374			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

**See schedule of adjustments attached at end of cost report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,844)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	48,710	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(81,101)	43		24
25	Fund Raising, Advertising and Promotional	(25,031)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,902)	43		28
29	Other-Attach Schedule See Schedule 5A	(521,089)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (592,257)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(172,878)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (172,878)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (765,135)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name Rest Haven West Christian Nursing Center
PROVIDER # 0028605
Period Ending 12/31/01

Schedule 5A

VI. ADJUSTMENT DETAIL
LINE 29 - Other

Description	Amount	Schedule V Reference
Disallow Dues	(745)	20
Residents Welfare	(9,480)	43
Uniform Income Offset	(199)	22
Vending Income Offset	(1,727)	2
Miscellaneous Income Offset	(9,086)	21
Public Aid Non-Reimbursed	(16,844)	43
Church/Civic	(250)	43
Trade Show	(24,601)	43
Gift Gratuities	(700)	43
Development	(7)	43
Interehab Physiatry	(69,525)	43
Out-of-State Travel	(2,659)	24
Disallow Real Estate Tax	(14,311)	33
Medicare Laboratory	(35,043)	43
Medicare X-Ray	(6,935)	43
Disallow Penalties	(2,132)	21
Disallow out-of-state travel	(1,240)	23
Disallow related party therapy	(325,605)	10A
Total	**(521,089)**	

See Accountants' Compilation Report

STATE OF ILLINOIS

Rest Haven West Christian Nursing Center

ID# 0028605

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,844)	0	0	0	0	0	0	0	0	0	0	(11,844)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,358	0	0	0	0	0	0	0	0	0	2,358	5
6	Maintenance	0	1,768	0	0	0	0	0	0	0	0	0	1,768	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(11,844)	4,126	0	0	0	0	0	0	0	0	0	(7,718)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(351,014)	0	0	0	0	0	0	0	0	0	(351,014)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,763	0	0	0	0	0	0	0	0	0	4,763	19
20	Fees, Subscriptions & Promotions	0	3,128	0	0	0	0	0	0	0	0	0	3,128	20
21	Clerical & General Office Expenses	0	57,016	0	0	0	0	0	0	0	0	0	57,016	21
22	Employee Benefits & Payroll Taxes	0	63,165	0	0	0	0	0	0	0	0	0	63,165	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	8,328	0	0	0	0	0	0	0	0	0	8,328	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,230	0	0	0	0	0	0	0	0	0	10,230	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(204,384)	0	0	0	0	0	0	0	0	0	(204,384)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(11,844)	(200,258)	0	0	0	0	0	0	0	0	0	(212,102)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Rest Haven West Christian Nursing Center **#** 0028605 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	48,710	19,568	0	0	0	0	0	0	0	0	0	68,278	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	7,812	0	0	0	0	0	0	0	0	0	7,812	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	48,710	27,380	0	0	0	0	0	0	0	0	0	76,090	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(108,034)	0	0	0	0	0	0	0	0	0	0	(108,034)	43
44	**TOTAL Special Cost Centers**	(108,034)	0	0	0	0	0	0	0	0	0	0	(108,034)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(71,168)	(172,878)	0	0	0	0	0	0	0	0	0	(244,046)	45

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian	100%	Rest Haven Central	Palos Heights, IL	Holland Home	South Holland, IL	Sheltered Care
Convalescent Home		Rest Haven South	South Holland, IL	Village Woods	Crete, IL	Independent Ret.
				Providence Mgmt. &		
				Development Co.	South Holland, IL	Management Co.
				Providence Home		
				Health Care	South Holland, IL	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 2,358	$ 2,358	1
2	V	6	Maintenance supplies		Rest Haven Illiana Christian Convalescent Home	100.00%	1,768	1,768	2
3	V	17	Management fees	351,014	Rest Haven Illiana Christian Convalescent Home	100.00%		(351,014)	3
4	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	4,763	4,763	4
5	V	20	Licenses, dues & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	3,128	3,128	5
6	V	21	Office		Rest Haven Illiana Christian Convalescent Home	100.00%	57,016	57,016	6
7	V	22	Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	63,165	63,165	7
8	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	8,328	8,328	8
9	V	26	Insurance		Rest Haven Illiana Christian Convalescent Home	100.00%	10,230	10,230	9
10	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	19,568	19,568	10
11	V	34	Rent		Rest Haven Illiana Christian Convalescent Home	100.00%	7,812	7,812	11
12	V								12
13	V								13
14	Total			$ 351,014			$ 178,136	$ * (172,878)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	See Schedule 7A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Convalescent
Street Address: 12450 West Cheshire Court
City / State / Zip Code: Lockport, IL 60441
Phone Number: (630) 645-2115
Fax Number: (630) 877-2103

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities-West	Accumulated Cost	64,669,983	14	$ 15,963	$	8,275,304	$ 2,043	1
2	5	Utilities-Saratoga	Accumulated Cost	64,669,983	14	15,963		1,275,201	315	2
3	6	Maintenance Supp.-West	Accumulated Cost	64,669,983	14	11,972		8,275,304	1,532	3
4	6	Maintenance Supp.-Saratoga	Accumulated Cost	64,669,983	14	11,972		1,275,201	236	4
5	19	Professional Fees-West	Accumulated Cost	64,669,983	14	32,253		8,275,304	4,127	5
6	19	Professional Fees-Saratoga	Accumulated Cost	64,669,983	14	32,253		1,275,201	636	6
7	20	Licenses, Dues-West	Accumulated Cost	64,669,983	14	21,178		8,275,304	2,710	7
8	20	Licenses, Dues-Saratoga	Accumulated Cost	64,669,983	14	21,178		1,275,201	418	8
9	21	Office-West	Accumulated Cost	64,669,983	14	386,073		8,275,304	49,403	9
10	21	Office-Saratoga	Accumulated Cost	64,669,983	14	386,073		1,275,201	7,613	10
11	22	Employee Benefits-West	Accumulated Cost	64,669,983	14	379,489		8,275,304	48,560	11
12	22	Employee Benefits-Saratoga	Accumulated Cost	64,669,983	14	379,489		1,275,201	7,483	12
13	22	Employee Benefits-West	Direct Cost	1	1	67,185		1	5,911	13
14	22	Employee Benefits-Saratoga	Direct Cost	1	1	67,185		1	1,211	14
15	24	Travel & Seminar-West	Accumulated Cost	64,669,983	14	56,391		8,275,304	7,216	15
16	24	Travel & Seminar-Saratoga	Accumulated Cost	64,669,983	14	56,391		1,275,201	1,112	16
17	26	Insurance-West	Accumulated Cost	64,669,983	14	69,272		8,275,304	8,864	17
18	26	Insurance-Saratoga	Accumulated Cost	64,669,983	14	69,272		1,275,201	1,366	18
19	30	Depreciation-West	Accumulated Cost	64,669,983	14	132,497		8,275,304	16,955	19
20	30	Depreciation-Saratoga	Accumulated Cost	64,669,983	14	132,497		1,275,201	2,613	20
21	34	Rent-West	Accumulated Cost	64,669,983	14	52,902		8,275,304	6,769	21
22	34	Rent-Saratoga	Accumulated Cost	64,669,983	14	52,902		1,275,201	1,043	22
23										23
24										24
25	TOTALS					$ 2,450,350	$		$ 178,136	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		x	Additions and renovations	$48,450.00	02/26/97	$ 5,515,700	$ 5,224,050	07/01/12	0.0536	$ 295,791	1
2	Notes		x	Facility Improvements	Various	Various	763,564	61,815	Various	Variable	16,828	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$48,450.00		$ 6,279,264	$ 5,285,865			$ 312,619	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,279,264	$ 5,285,865			$ 312,619	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ N/A	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996		8
	1997		9
	1998		10
	1999		11
	2000		12

This facility does not have real estate taxes because it is a not-for-profit organization.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven West Christian Nursing Center COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0028605

CONTACT PERSON REGARDING THIS REPORT Bill DeYoung

TELEPHONE (708) 645-2115 FAX #: (708) 877-2103

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.		N/A	$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? N/A YES N/A NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 105,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: None
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,200	1984	$ 339,570	1
2					2
3	TOTALS	29,200		$ 339,570	3

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	241		1984	1962	$ 86,903	$ 2,172	40	$ 2,162	$ (10)	$ 86,903	4
5				1972	889,527	22,238	40	22,238		667,140	5
6				1973	34,742	869	40	869		25,201	6
7				1974	7,414	185	40	185		5,180	7
8				1975	55,878	1,397	40	1,397		37,719	8
	Improvement Type**										
9	Improvement			1976	4,115	103	40	103		2,678	9
10	Improvement			1977	33,527	838	40	838		20,950	10
11	Improvement			1980	6,049	151	40	151		3,322	11
12	Improvement			1981	7,380	185	40	185		3,885	12
13	Improvement			1983	22,839	571	40	571		10,849	13
14	Improvement			1984	370,014	9,250	40	9,250		166,500	14
15	Improvement			1985	297,491	7,437	40	7,437		126,429	15
16	Improvement			1986	275,406	6,885	40	6,885		110,160	16
17	Improvement			1987	24,035	601	40	601		9,015	17
18	Improvement			1988	509,896	12,747	40	12,747		178,458	18
19	Improvement			1989	4,381,420	109,536	40	109,536		1,423,968	19
20	Improvement			1989	90,660	2,267	40	2,267		29,471	20
21	Improvement			1990	155,196	3,880	40	3,880		46,560	21
22	Improvement			1991	5,021	126	40	126		1,386	22
23	Improvement			1992	75,453	1,886	40	1,886		18,860	23
24	Improvement			1993	26,281	657	40	657		5,913	24
25	Improvement			1994	16,231	405	40	405		3,240	25
26	Improvement			1995	128,962	3,224	40	3,224		20,956	26
27	Sign and landscaping			1996	4,764	119	40	119		655	27
28	Fence			1996	1,565	40	40	40		220	28
29	Renovate laundry and break rooms			1996	4,400	110	40	110		605	29
30	Whirlpool tubs			1996	20,200	505	40	505		2,777	30
31	Side rails			1996	2,293	57	40	57		314	31
32	Phone system			1996	35,085	877	40	877		4,823	32
33	Parking Lot			1997	15,078	377	40	377		1,697	33
34	Landscaping			1997	10,839	271	40	271		1,219	34
35	Dining room renovation			1997	1,193	30	40	30		135	35
36	Hospitality room renovation			1997	34,830	871	40	871		3,919	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Activity / class room renovation	1997	$ 3,476	$ 87	40	$ 87	$	$ 391	37
38	Carpeting	1997	1,521	38	40	38		171	38
39	Railing	1997	500	13	40	13		58	39
40	Laundry / break room renovation	1998	6,864	172	40	172		602	40
41	Compressor	1998	917	92	10	92		322	41
42	Roof repair	1998	2,320	232	10	232		812	42
43	Alarm system	1998	1,056	106	10	106		371	43
44	Hospitality room renovation	1998	12,605	316	40	316		1,106	44
45	Carpeting	1998	76,503	15,300	5	15,300		53,550	45
46	Wallpaper	1998	40,287	8,058	5	8,058		28,203	46
47	Roofing	1999	208,749	20,874	10	20,874		52,185	47
48	Therapy room renovation	1999	23,731	2,374	10	2,374		5,935	48
49	Resident room lighting	1999	23,965	2,396	10	2,397	1	5,990	49
50	Phone upgrade	1999	2,470	248	10	248		620	50
51	Renovations	1999	47,385	4,738	10	4,738		11,847	51
52	New door on oxygen room	1999	1,993	194	10	194		486	52
53	Landscaping	2000	59,350	1,484	40	1,484		2,226	53
54	Benches	2000	2,500	63	40	63		94	54
55	Room 18 renovation, wallcover, painting, tiling and carpeting	2000	7,682	768	10	768		1,152	55
56	Therapy renovation, wallcover, painting and tiling	2000	28,849	2,885	10	2,885		4,327	56
57	Beauty renovation, wallcover, painting, tiling and carpeting	2000	31,764	3,176	10	3,176		4,764	57
58	Common renovation, wallcover, painting, tiling, and carpeting	2000	42,312	4,231	10	4,231		6,347	58
59	Kitchen renovation, wallcover, painting, and tiling	2000	24,995	2,500	10	2,500		3,750	59
60	HVAC	2000	32,028	3,203	10	3,203		4,804	60
61	Doors	2000	3,300	330	10	330		495	61
62	Countertop	2000	654	65	10	65		98	62
63	Sprinkler System	2001	39,878	805	40	498	(307)	498	63
64	Benches	2001	2,455	94	40	31	(63)	31	64
65	Room Renovations	2001	1,398,437	63,725	10	69,922	6,197	69,922	65
66	Rehab Renovations	2001	98,080	802	10	4,904	4,102	4,904	66
67	Nurse Call System	2001	114,755	4,371	10	5,738	1,367	5,738	67
68	Kitchen Renovations	2001	3,800	16	10	190	174	190	68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,979,868	$ 334,623		$ 346,084	$ 11,461	$ 3,293,096	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,979,868	$ 334,623		$ 346,084	$ 11,461	$ 3,293,096	1
2	HVAC	2001	3,000	180	10	150	(30)	150	2
3	Doors	2001	3,187	14	10	159	145	159	3
4	Office Remodeling	2001	35,071	1,132	10	1,754	622	1,754	4
5	HVAC	2001	28,200	1,514	10	1,410	(104)	1,410	5
6	Carpeting	2001	6,612		10	331	331	331	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32	Prior year disposal being researched		(116,300)					(27,598)	32
33	Book depreciation on assets disallowed for Medicaid			33,124			(33,124)		33
34	TOTAL (lines 1 thru 33)		$ 9,939,638	$ 370,587		$ 349,888	$ (20,699)	$ 3,269,302	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,939,638	$ 370,587		$ 349,888	$ (20,699)	$ 3,269,302	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,939,638	$ 370,587		$ 349,888	$ (20,699)	$ 3,269,302	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,939,638	$ 370,587		$ 349,888	$ (20,699)	$ 3,269,302	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,939,638	$ 370,587		$ 349,888	$ (20,699)	$ 3,269,302	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,197,040	$ 120,899	$ 221,295	$ 100,396	10	$ 1,707,275	71
72	Current Year Purchases	217,745	38,501	10,887	(27,614)	3-10 yrs	10,887	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,568	19,568			74
75	TOTALS	$ 2,414,785	$ 159,400	$ 251,750	$ 92,350		$ 1,718,162	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1984 Ford Bus	1989	$ 47,590	$ 3,373	$	$ (3,373)	5	$ 47,590	76
77	Resident Care	1995 Chevrolet K20 Truck	1995	22,494				5	22,494	77
78										78
79										79
80	TOTALS			$ 70,084	$ 3,373	$	$ (3,373)		$ 70,084	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,764,077	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 533,360	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 601,638	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 68,278	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,057,548	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Home Office Allocation				7,812			6
7	TOTAL				$ 7,812 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A N/A

9. Option to Buy: [ ] YES [x] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$ N/A
13.	/2003	$ N/A
14.	/2004	$ N/A

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L. 10a C 3	hrs	$	4,737	$ 179,370	$	4,737	$ 179,370	1
2	Licensed Speech and Language Development Therapist	L. 10a C 3	hrs		1,284	72,245		1,284	72,245	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10a C 3	hrs		4,720	226,086		4,720	226,086	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39 C 2	# of prescrpts				481,641		481,641	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	10,741	$ 477,701	$ 481,641	10,741	$ 959,342	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,200	$ 1,200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 209,430)	1,510,074	1,510,074	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	16,000	16,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,527,274	$ 1,527,274	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	10,950,853	9,939,638	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,560,209	2,484,869	16
17	Accumulated Depreciation (book methods)	(6,023,752)	(5,057,548)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,846,228	$ 7,706,529	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 9,373,502	$ 9,233,803	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 958,155	$ 958,155	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,973	1,973	28
29	Short-Term Notes Payable	61,815	61,815	29
30	Accrued Salaries Payable	329,214	329,214	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,795	3,795	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	5,059,387	5,059,387	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,414,339	$ 6,414,339	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		5,224,050	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,224,050	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,414,339	$ 11,638,389	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,959,163	$ (2,404,586)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 9,373,502	$ 9,233,803	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/01**

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities **Line 36, Other Current Liabilities (specify):**	Operating	After Consolidation
Dental Withholding	1,157	1,157
Health Insurance Withholding	11,943	11,943
TDA Withholding	32,548	32,548
Mony Life Insurance Withholding	363	363
Life Insurance Withholding	67	67
Standard Withholding	472	472
Due to Related Parties	5,012,837	5,012,837
Total	5,059,387	5,059,387

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,823,487	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	1,439	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,824,926	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	134,237	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 134,237	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,959,163	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,342,963	1
2	Discounts and Allowances for all Levels	(1,871,550)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,471,413	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,194,725	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,194,725	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,662	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	385,835	17
18	Sale of Supplies to Non-Patients	30,948	18
19	Laboratory	68,709	19
20	Radiology and X-Ray	12,740	20
21	Other Medical Services	154,720	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 664,614	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	12,994	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,994	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,343,746	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,104,450	31
32	Health Care	4,434,690	32
33	General Administration	1,975,326	33
	B. Capital Expense		
34	Ownership	860,290	34
	C. Ancillary Expense		
35	Special Cost Centers	753,060	35
36	Provider Participation Fee	81,693	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,209,509	40
41	**Income before Income Taxes (line 30 minus line 40)****	134,237	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 134,237	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/01**

Schedule 19 A

XVII. INCOME STATEMENT
E. Other Revenue

	Amount
Recreation Hall	1,800
Food/Vending	1,727
Other Income	9,086
Uniform Income	199
Employee Meals	182
Total	12,994

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,832	2,080	$ 62,440	$ 30.02	1
2	Assistant Director of Nursing	1,794	1,944	44,358	22.82	2
3	Registered Nurses	48,603	53,399	925,882	17.34	3
4	Licensed Practical Nurses	22,904	24,455	470,850	19.25	4
5	Nurse Aides & Orderlies	105,222	112,466	1,455,900	12.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,736	2,030	23,631	11.64	9
10	Activity Assistants	7,562	8,477	143,570	16.94	10
11	Social Service Workers	5,291	6,136	115,046	18.75	11
12	Dietician	1,880	2,080	53,440	25.69	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	57,689	62,021	588,404	9.49	15
16	Dishwashers					16
17	Maintenance Workers	5,214	5,495	139,594	25.40	17
18	Housekeepers	15,841	17,580	200,987	11.43	18
19	Laundry	8,015	8,708	81,558	9.37	19
20	Administrator	2,080	2,080	73,794	35.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,177	30,107	557,190	18.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,265	1,354	16,835	12.43	31
32	Other Health Ca See Sch20A	1,961	2,233	54,793	24.54	32
33	Other(specify) See Sch20A	1,600	1,699	36,459	21.46	33
34	TOTAL (lines 1 - 33)	316,666	344,344	$ 5,044,731 *	$ 14.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant	Monthly	4,032	L10, C3	37
38	Nurse Consultant	Monthly	2,400	L10, C3	38
39	Pharmacist Consultant	Monthly	1,595	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,352	L11, C3	44
45	Social Service Consultant	Monthly	2,250	L12, C3	45
46	Other(specify) Chapel Ministry	various	910	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	50	$ 27,939		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	389	$ 5,882	L10, C3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	389	$ 5,882		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	**Rest Haven West Christian Nursing Center**
PROVIDER #	**0028605**
Period Ending	**12/31/01**

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Employee Educator	1,961	2,233	54,793	24.54	10
Total Line 32 - Other Health Care	**1,961**	**2,233**	**$ 54,793**	**$ 24.54**	
Case Manager	1,600	1,699	36,459	21.46	21
Total Line 33 - Other	**1,600**	**1,699**	**$ 36,459**	**$ 21.46**	

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine DeVries	Administrator	0%	$ 73,794
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,794

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 351,014
TOTAL (agree to Schedule V, line 17, col. 3)	$ 351,014
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin &		$
Glasser, LLP	Accounting	7,978
KPMG Peat Marwick LLP	Accounting	10,220
Laner, Muchin, Dombrow, Becker		
Levin and Tominberg, Ltd.	Legal	2,814
SMS	Medicare Billing	6,439
American Express Tax & Bus. Svc.	Consulting	820
Zenny Floresca	Consulting	1,000
Achieve Accreditation	Consulting	4,837
Alternative Staffing Resource	Consulting	5,500
AMA Profile	Consulting	255
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 39,863

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,929
Unemployment Compensation Insurance	11,541
FICA Taxes	348,812
Employee Health Insurance	178,218
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	45,380
Employee Vaccinations/Medical	2,046
Drug Testing	4,572
TDA Expense	57,627
Employee Education	1,423
Uniforms	198
Home Office Allocation	63,165
TOTAL (agree to Schedule V, line 22, col.8)	$ 781,911

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,693
Health Care Worker Background Check	
(Indicate # of checks performed 21)	252
Life Services Network	15,969
Health Resources Alliance	8,333
Miscellaneous Licenses and Dues	265
Miscellaneous Subscriptions	526
Home Office Allocation	3,128
JCAHO	10,316
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,482

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,647
Home Office Allocation	8,328
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,975

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name	**Rest Haven West Christian Nursing Center**
PROVIDER #	**0028605**
Period Ending	**12/31/01**

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	39,863
Allocated from Home Office	4,763
Total (agree to Schedule V, line 19, column 8)	44,626

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN: $15,969; HRA: $8,333**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6.5 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **70,956** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **81,693**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **N/A** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **11,844**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	641,844	79,386	0	721,230	0	721,230	0	721,230
2. Food Purchase	0	487,823	0	487,823	0	487,823	-13,571	474,252
3. Housekeeping	200,987	31,395	0	232,382	0	232,382	0	232,382
4. Laundry	81,558	22,306	0	103,864	0	103,864	0	103,864
5. Heat and Other Utilities	0	0	200,751	200,751	0	200,751	2,358	203,109
6. Maintenance	139,594	0	218,806	358,400	0	358,400	1,768	360,168
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,063,983	620,910	419,557	2,104,450	0	2,104,450	-9,445	2,095,005
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	3,031,058	254,681	13,909	3,299,648	0	3,299,648	0	3,299,648
10a. Therapy	0	0	803,306	803,306	0	803,306	-325,605	477,701
11. Activities	167,201	22,207	2,352	191,760	0	191,760	0	191,760
12. Social Services	115,046	7,370	3,160	125,576	0	125,576	0	125,576
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,313,305	284,258	837,127	4,434,690	0	4,434,690	-325,605	4,109,085
17. Administrative	73,794	0	351,014	424,808	0	424,808	-351,014	73,794
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	39,863	39,863	0	39,863	4,763	44,626
20. Fees, Subscriptions & Promotion	0	0	39,099	39,099	0	39,099	2,383	41,482
21. Clerical & General Office	593,649	11,631	54,989	660,269	0	660,269	45,798	706,067
22. Employee Benefits & Payroll	0	0	718,945	718,945	0	718,945	62,966	781,911
23. Inservice Training & Education	0	0	1,240	1,240	0	1,240	-1,240	0
24. Travel and Seminar	0	0	11,306	11,306	0	11,306	5,669	16,975
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	79,796	79,796	0	79,796	10,230	90,026
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	667,443	11,631	1,296,252	1,975,326	0	1,975,326	-220,445	1,754,881
29. Total General Administrative	5,044,731	916,799	2,552,936	8,514,466	0	8,514,466	-555,495	7,958,971
30. Depreciation	0	0	533,360	533,360	0	533,360	68,278	601,638
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	312,619	312,619	0	312,619	0	312,619
33. Real Estate	0	0	14,311	14,311	0	14,311	-14,311	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	7,812	7,812
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	860,290	860,290	0	860,290	61,779	922,069
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	481,641	0	481,641	0	481,641	0	481,641
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	81,693	81,693	0	81,693	0	81,693
43. Other (specify):*	0	0	271,419	271,419	0	271,419	-271,419	0
44. Total Special Cost Ce	0	481,641	353,112	834,753	0	834,753	-271,419	563,334
45. Grand Total	5,044,731	1,398,440	3,766,338	10,209,509	0	10,209,509	-765,135	9,444,374

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,200	1,200
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,510,074	1,510,074
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	16,000	16,000
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,527,274	1,527,274
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	358,918	339,570
14. Buildings, at Historical Cost	10,950,853	9,939,638
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	2,560,209	2,484,869
17. Accumulated Depreciation (book methods)	-6,023,752	-5,057,548
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	7,846,228	7,706,529
25. Total Assets	9,373,502	9,233,803
CURRENT LIABILITIES		
26. Accounts Payable	958,155	958,155
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	1,973	1,973
29. Short-Term Notes Payable	61,815	61,815
30. Accrued Salaries Payable	329,214	329,214
31. Accrued Taxes Payable	3,795	3,795
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	5,059,387	5,059,387
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	6,414,339	6,414,339
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	5,224,050
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,224,050
46.Total Liabilities	6,414,339	11,638,389
47.Total Equity	2,959,163	-2,404,586
48.Total Liabilities and Equity	9,373,502	9,233,803

		Balance per Medicaid Trial Balance
1.	Gross Revenue - All levels of Care	9,342,963
2.	Discounts and Allowances for all Levels	-1,871,550
	Subtotal - Inpatient Care	7,471,413
4.	Day Care	0
5.	Other Care for Outpatients	0
6.	Therapy	2,194,725
7.	Oxygen	0
	Subtotal - Anciliary Revenue	2,194,725
9.	Payments for Education	0
10.	Other Governmental Grants	0
11.	Nurses Aide Training Reimbursements	0
12.	Gift and Coffee Shop	0
13.	Barber and Beauty Care	0
14.	Non-Patient Meals	11,662
15.	Telephone, Television, and Radio	0
16.	Rental of Facility Space	0
17.	Sale of Drugs	385,835
18.	Sale of Supplies to Non-Patients	30,948
19.	Laboratory	68,709
20.	Radiologyand X-Ray	12,740
21.	Other Medical Services	154,720
22.	Laundry	0
	Subtotal - Other Operating Revenue	664,614
24.	Contributions	0
25.	Interest and Other Investments Income	0
	Subtotal - Non-Operating Revenue	-
27.	Other Revenue (specify):	12,994
28.	Other Revenue (specify):	0
	Subtotal - Other Revenue	12,994
30.	Total Revenue	10,343,746
31.	General Services	2,104,450
32.	Health Care	4,434,690
33.	General Administration	1,975,326
34.	Ownership	860,290
35.	Special Cost Centers	753,060
35.	Provider Participation Fee	81,693
37.	Other	0
40.	Total Expenses	10,209,509
41.	Income Before Income Taxes	134,237
42.	Income Taxes	0
43.	Net Income or Loss for the Year	134,237

Page

Attachment of Real Estate Bill and fill out form

P12 does not show totals, it carries to P12a, therefore P12a must always be attached

The bottom right side of page under **, you must write in any comments

RECONCILIATION REPORT **Rest Haven West Christi** **03:58 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-765,135	equal to	-765,135	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	312,619	equal to	312,619	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	601,638	equal to	601,638	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	7,812	equal to	7,812	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	477,701	equal to	803,306	-325,605	FAILED	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	481,641	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,104,450	equal to	2,104,450	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,434,690	equal to	4,434,690	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,975,326	equal to	1,975,326	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	860,290	equal to	860,290	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	753,060	equal to	753,060	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	81,693	equal to	81,693	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,976,265	equal to	3,031,058	-54,793	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	167,201	equal to	167,201	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	115,046	equal to	115,046	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	641,844	equal to	641,844	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	139,594	equal to	139,594	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	200,987	equal to	200,987	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	81,558	equal to	81,558	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	73,794	equal to	73,794	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	557,190	equal to	593,649	-36,459	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,044,731	equal to	5,044,731	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	13,909	< or = to	13,909	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,352	< or = to	2,352	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,250	< or = to	3,160	-910	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	73,794	equal to	73,794	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	351,014	equal to	351,014	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	39,863	equal to	39,863	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	781,911	equal to	781,911	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	41,482	equal to	41,482	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	16,975	equal to	16,975	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	81,693	equal to	81,693	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	62,966	-62,966	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,840	equal to	4,515	-675	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-172,878	equal to	-172,878	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,285,865	equal to	5,285,865	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	339,570	equal to	339,570	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	9,939,638	equal to	9,939,638	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	2,484,869	equal to	2,484,869	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	5,057,548	equal to	5,057,548	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,959,163	equal to	2,959,163	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	134,237	equal to	134,237	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	9,373,502	equal to	9,373,502	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1